DOMINION DDS DENTAL Services, Inc.

CHANGE IN COVERAGE FORM

❑ Change Plans: ❑ Address/Name Change ❑ Add Dependents
❑ Select Plan ❑ Terminate Subscriber ❑ Delete Dependents
❑ Access PPO Plan ❑ Split Dental Centers ❑ Change Dental Office (SELECT PLAN ONLY)

Changes to Subscriber Information

Social Security Number: — —	Plan Number:	Sex (circle one): MALE FEMALE	
Last Name:	First Name:	MI:	Birthdate *(mm/dd/yy)*: / /
Home Address:			Telephone (Home):
City:	State:	Zip Code:	Telephone (Work):

Changes to Selected Dental Office (SELECT PLAN ONLY)

Dental Office Code:	Dental Office Name:

Changes to Spouse Information

	Sex (M/F)	Last Name *(If different)*	First Name	MI	DOB	SELECT PLAN ONLY: Dental Office *(if different)*
❑ Add ❑ Delete					/ /	

Changes to Dependent Information

	Sex (M/F)	Last Name *(If different)*	First Name	MI	DOB	SELECT PLAN ONLY: Dental Office *(if different)*
❑ Add ❑ Delete					/ /	
❑ Add ❑ Delete					/ /	
❑ Add ❑ Delete					/ /	
❑ Add ❑ Delete					/ /	

Authorization

_____ _____
Subscriber's Signature Date

To Be Completed By Benefits Administrator

Group Number:	Group Name:	Effective Date of Change: / / Mo. Day Yr.

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